SUMMARY

Communication between physicians and patients is a key element in cancer care and entails several aspects such as maintaining hope while discussing poor prognosis, coping with uncertainty, explaining and managing treatment effects and side effects, addressing end-of-life issues, and facing emotional distress and other reactions in both patients and physicians. The challenges in current healthcare communication research are to address this complexity and investigate the subjectivity and context-dependent nature of communication, as well as physicians’ flexibility, motivation, and resources.

The overall aim of this thesis was to investigate physicians’ defensive functioning during communication with patients suffering from advanced cancer and to explore the relationships between defensive functioning and patient outcome (satisfaction with communication and working alliance) and contextual characteristics (of the physician, the patient, and the consultation). Defined as part of a person’s affect regulation, defences – self-protective psychological mechanisms triggered by an affective load – are supposed to help individuals, like the physician, to adapt to and/or protect oneself from stress. Moreover, defences have been proposed as a way to conceptualize the emotional distance or connection which the physician establishes with his patient. Various types of defence mechanisms have been identified and can be classified depending on their degree of adaptation to or distortion of reality. These range from “immature or low defences” (i.e., distorting reality and/or emotions) to “mature or high defence” (i.e., staying closer to reality and to emotions). A single Overall Defensive Functioning score (ODF) can be calculated for each consultation, positioning the defensive functioning of the physician during that consultation on the mature/immature scale with a score of 7 being completely mature and a score of 1 being completely immature.

First, the existing scientific knowledge with regard to the impact of physicians’ characteristics on both patient-physician communication and on patient outcome (physical and psychological) in oncology was reviewed. In Chapter 2 the systematic literature review revealed a positive impact of physicians’ communication skills training, external locus of control, empathy, socio-emotional approach, shared decision-making style, anxiety, and mature defensive functioning on quality of communication and/or patient outcome. A negative impact was reported for physicians’ level of fatigue and burnout and expression of worry. Professional experience of physicians was not related to the quality of the communication and/or to patient outcome, and divergent results were reported with respect to physicians’ gender, age, stress, posture, and confidence or self-efficacy.

Alexithymia (the difficulty to identify and describe emotions in oneself and in others) might be considered a form of emotional detachment that serves a global defensive function. It is suggested to play a role in the onset or development of psychiatric and physical health problems, such as stress-related disorders and cancer. It is also suspected to have an impact on patient outcome. In Chapter 3 we reviewed the scientific literature on alexithymia in patients suffering from cancer. Patients’ alexithymia was positively related to patients’ state (anxiety and depression) but whether it could be related to physicians’ affect regulation during communication with patients remained to be studied. Still, patients’ alexithymia seemed to be related, possibly as a mediating factor (e.g., with regard to stress and coping with stress), with the immune system, with patients’ emotional inhibition, and with intensity, interference and quality of pain among other variables.

At the centre of the framework of this thesis is the physician’s defensive functioning. In Chapter 4 results of the naturalistic multi-centred observational study in different hospitals in Switzerland showed that the use of four defences (i.e., displacement, self-devaluation, acting-out and hypochondriasis) and the physician’s level of stress had a negative relationship with patient satisfaction and patient-perceived alliance. The content of the consultation (good versus bad test results) had no relationship with patient outcomes. No defences were found with a positive effect on patient outcome. These results suggested that some of physicians’ defence mechanisms, although they might momentarily protect the physician, can indeed hamper the patient-physician relationship (working alliance) and the patient’s satisfaction with the consultation. This is important as alliance is a powerful variable in patient-physician communication. The physician’s defensive functioning might thus alienate the physician from the patient, thereby preventing support and relationship building and, ultimately, hampering positive treatment outcome.
However, the majority of defences had no relationship with patient outcome, and might only have a function for the physician’s well-being, or be confounded by other variables. This is illustrated by the link between physicians’ stress and patient outcome emphasizing the importance that should be given to physicians’ perceived stress as it indicates or even precipitates patient dissatisfaction with the consultation and a suboptimal alliance between physician and patient. Furthermore, the surprising absence of a relationship between content of the consultation (bad versus good news) and patient outcomes could possibly be explained by the likelihood that the same content can be differently interpreted by physicians or patients, or, alternatively, the absence of a relationship might be a sign that physicians now succeed in adapting to their patients in bad news situations.

In Chapter 5 a lower Overall Defensive Functioning was observed for the more alexithymic physicians in our study, while the frequency of defences increased depending on the context; especially when patients reported more sadness and the physician felt more stress. Neither physicians’ experience nor training, nor patients’ alexithymia were related to physicians’ defensive functioning. Physician with a more mature defensive functioning were more independent of (inner) context and might thus maintain the ability to keep a relationship with the patients throughout different stress levels, and by doing so fulfil a critical element of good patient care. When a physician is detached from his or her emotions (e.g., alexithymic), he or she might not be able to recognize them and thus lack the ability to manage them in a mature way. Overall Defensive Functioning and alexithymia might both illustrate more global functioning independent of situational factors but related to each other. Even though it might sometimes be adaptive to distance oneself from hurtful emotions that might otherwise be overwhelming, when this emotional detachment is no longer situational but becomes structural for a physician, the alexithymic functioning might hamper the therapeutic relationship with patients by producing a lack of connection and a sense of interchangeability (i.e., that either the patient or the physician could be replaced by any other patient/physician without being missed), which might alienate and isolate them both.

Finally, in Chapter 6, the main findings of this thesis were summarized and put into perspective by discussing the complexity of communication and of defensiveness, the paradoxes in healthcare communication and the implications for clinical care and for communication education. Recommendations for future research were given.

To conclude, the present thesis advances our understanding of healthcare communication and more specifically of the defensive functioning of physicians themselves during real life consultations with patients suffering from advanced cancer. The main research questions of this thesis were whether the physicians’ defensive functioning, perceived stress or the content of the consultation were related to the patient’s satisfaction with communication and working alliance; and whether physician and/or patient variables were related to physicians’ defensive functioning. The results suggested that some of physicians’ defence mechanisms, although they might momentarily protect the physician, can indeed hamper the patient-physician relationship (working alliance) and the patient’s satisfaction with the consultation. However, the majority of defences had no relationship with patient outcome, and might only have a function for the physician’s well-being, or be confounded by other variables. Furthermore, Overall Defensive Functioning - indicating the overall maturity of the defences used - might be predominantly a stable trait, while the number of defences used might depend on the physician’s outer world (the patient’s state) and inner world (the level of stress). Physicians with a more mature defensive functioning were more independent of (inner) context and might thus maintain the ability to keep a relationship with the patient throughout different stress levels.